

Raising concerns about poor nursing care: the moral  
and professional responsibility of nursing students  
and registered nurses.



A thesis submitted for the degree of Doctor of Philosophy  
(PhD)

by

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## Declaration

Candidate's declarations:

I, Robin Ion hereby certify that this thesis submitted in partial fulfilment of the requirements for the award of [insert qualification e.g. Doctor of Philosophy (PhD), Abertay University, is wholly my own work unless otherwise referenced or acknowledged. This work has not been submitted for any other qualification at any other academic institution.

Signed

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Date 5<sup>th</sup> February

2019.....

Supervisor's declaration:

I, David Lavalley, hereby certify that the candidate has fulfilled the conditions of the Resolution and Regulations appropriate for the degree of PhD in Abertay University and that the candidate is qualified to submit this thesis in application for that degree.

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Date 5<sup>th</sup> February

2019.....

## **Certificate of Approval**

I certify that this is a true and accurate version of the thesis approved by the examiners, and that all relevant ordinance regulations have been fulfilled.

Supervisor.....

Date.....

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Particular thanks go to David Lavalley – he has guided me through the challenge of producing this submission. Always encouraging, he has offered sound advice throughout.

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Thanks also to Joe Armstrong.

## **Dedication**

For my wife, Nicky, and daughter, Eve, and for my Dad, whose care was often poor – he deserved better. Abstract

## **Abstract**

### **Background and rationale**

This work is presented against a background of concern about aspects of the quality of care provided by health services in the UK and beyond, with much of this related to nursing care in particular.

It is specifically concerned with the responsibilities of nursing students and registered nurses who are witness to instances of patient abuse, neglect or incompetence, in other words, poor care.

### **Key ideas**

Over thirteen peer reviewed publications, including empirical work, a systematic review, discussion, philosophical and educational papers, it argues that poor care is a reality across the world. In addition, despite clear legal, moral and professional guidance and expectation, those who witness it sometimes fail to raise a concern, leaving vulnerable patients at risk. It provides some of the earliest explanations for this phenomenon among student nurses, and argues that these bystanders are obligated to take action to protect those in their care. Moreover, drawing on the idea of free will, it makes the case that they are free to do so, albeit with some potential consequences.

### **Conclusions**

In order to address the failure to speak out in the face of poor care significant consideration must be given to the education and preparation of practitioners for the world of clinical practice. This should include steps to develop student understanding of their professional and moral obligations, as well as approaches which promote the development of moral courage and the ability to think critically. Change is most likely to occur if these issues are addressed against a backdrop of strategic engagement, where policy and process is clear and where academic and practice leaders model openness and transparency.



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# **1. Chapter One**

## **1.1 Aim of the chapter**

In the subsections below I provide a critical reflexive account of the influences which shaped the research and how it in turn has impacted me. I describe the background and context to the problem of poor care and provide a definition of the concept - distinguishing it from errors and mistakes. I explain what nurses are expected to do if they encounter poor care and outline what we know about how they actually respond in the real world. I also discuss the impact of poor care on patients and describe the potential consequences for perpetrators, as well as those who are witnesses to it.

## **1.2 On critically reflexivity**

In this section, I draw on ideas outlined by Northway (2000) and McCabe and Holmes (2009) in relation to critical reflexivity. I first situate the work in my own personal history. My aim here is to make clear the potential for subjectivity in the thesis and in doing this to better enable the reader to make their own judgements and draw their own conclusions about its value. Following this I explain how the unfolding of the project has influenced me as a nurse academic and researcher.

This thesis developed as a result of a number of loosely related influences. Although it is difficult to be sure of the degree to which they have impacted the outcome, and while I have taken the traditional approaches to maximising objectivity, there is no doubt for me that they have played some part.

A long standing interest in politics helped me to develop a fairly healthy scepticism of ideology in general and of both personal and professional myths and stereotypes in particular - particularly in relation to nurses and especially when these presented caricatures of selfless goodness or monstrous personal evil. My own experience of people, including nurses, has been that they are neither of these. Rather they are inclined toward a middle position where, in most cases, they behave well and act decently, with occasional examples of both great humanity and individual low level cruelty. This expectation of an

occasional tendency toward personal failure when the circumstances make prosocial behaviour more difficult may well be written through this work to a degree to which that I am unaware.

I have also, on many occasions, seen poor care as a relative of an ageing and increasingly frail parent. In all cases it seemed to me to be a consequence of a combination of lack of thought for another person, coupled with basic stupidity - I know this is an unprofessional statement, but for this moment, I am my father's son and what I saw was sometimes stupid. His care was often substandard.

Almost every person I know of my age, who has elderly parents, has a similar story to mine. Without doubt, experiences of this type have influenced me.

They have also caused me to reflect on my own history of personal and professional failure. I have a notion that most health professionals, if they care to think hard enough, will be able to identify situations when they could have been kinder, more courageous, given more time or been less impatient. I certainly can. In a way this body of work is about trying to work through some of that stuff in my own head. The personal action and responsibility I advocate hold good for me too.

I have also been heavily influenced by literature - fiction, fact, history and philosophy. Two books particularly stand out for me. *The Fall* by Camus (2006) is a short novel in which a once successful French lawyer recounts to a stranger in a seedy bar, his own story of personal failure - in this case the decision to put his own safety above the needs of a suicidal other. By the end of the story the reader knows they would do the same if faced with a similar situation. The second is Hannah Arendt's (1961) *Eichmann in Jerusalem*. An account of the trial of the Nazi and holocaust organiser, Adolf Eichmann, it argues that despite his undoubted guilt and the enormity of his crimes, the defendant lacked malign intent. Rather his actions and failures were borne out of an inability to think critically or deeply about the business in which he was engaged. This issue is explored again later in the thesis. For now its significance lies in the fact that it alerted me to the possibility that bad things and wicked actions could be carried out by people other than monsters and sociopaths.

I have also been influenced by the many discussions I have had in the classroom with students. Listening to their stories, it became clear to me that they not infrequently found themselves in situations where care provision was

sub-optimal, or frankly poor. For some time I was unsure about what should be done about this. Eventually it became clear that I needed to do something. At a more prosaic level, the work developed out of necessity. My initial interest in the role of the student in raising concerns about poor care, came about when I was head of a nursing department. The professional regulator made it clear that we must have a process and policy which students could follow, so I developed one. I became interested from there. I also knew that I needed to publish and it soon became clear to me that this area had considerable potential. I was also genuinely curious about how people managed situations where they felt something wrong had occurred - I wanted to know what they did and why they acted in these ways. Camus' lawyer certainly influenced this interest.

All of the above have played a part of some sort or other in the development of the papers which comprise this thesis. I would not change the influences, with the exception of those relating to my father, but I have taken steps to minimise personal bias. I have worked with others who revised my analysis of data, submitted work for peer review and sought advice and thoughts from those whose views differ from mine. I have also tested out some of the arguments in meetings and at conferences and in the classroom. I think they hold good.

In terms of personal and professional development, the work has had a huge influence on me. Aside from the technical skills of writing, project design, literature searching, critical appraisal, data collection, analysis etc., it has changed the way I think, teach and act. For example discovering social constructionism taught me that the world could, has been, and will be organised very differently. It showed me that language is not only a way of transmitting information, it also makes the world in which we live. I learned that knowledge was provisional and that it is not only good, but essential to be curious and sceptical. I discovered that there is a danger in only engaging with those who share my own world view - listening to and speaking with those who see things very differently is something I have come to enjoy in a way I previously had not. On a very personal level this is manifested in a move away from a lifelong



allegiance to left of center politics - I was alerted to the fact that morality is not just the preserve of the left.

The technical skills I have developed in becoming a researcher have helped to make me a more thoughtful teacher. Where once I was focused on getting across information, I am now more likely to spend time encouraging students to explore an idea and to think about its meaning and implications. I am much more inclined to interpret and apply learning and ideas than I once was. I hope this has made me a more useful teacher. I have also learned to be mindful of the degree to which even the very small actions of academics can impact students. When analysing the data for what became Ion et al. (2015), I came across a reflection from a participant who said they would not raise a concern about care with a particular member of academic staff. The reason given related to an earlier incident when they had sought the help of that person over something relatively insignificant. According to the student, the academic had been dismissive and the student had never forgotten this. My guess is that the academic had long forgotten the incident, but the student had not. I learned that lack of trust made it even harder to raise concerns, and that I had to work to be consistently trustworthy in the eyes of students.

The most significant change relates to my thoughts on personal and professional responsibility for action and omission. Like some of those I interviewed for the papers in the thesis, I once thought that there were limits on what we could reasonably expect of ourselves and others when faced by injustice or unfairness. Over the course of the work I have come to see things differently. There are indeed limits on what we can expect, but these are not always present, and regardless, the failure to stand up to poor practice is a breach of moral expectation and professional guidance. When we take the decision to remain silent about these things we should accept the responsibility that goes with silence. This is an uncomfortable position to hold, but it is now how I see things. This, I think, might be akin to the emancipatory reflexivity referred to by McCabe and Holmes (2009). In the process of the work something has changed for me and I now see a small part of the world differently to how I once did. What this means is that I am obliged to try and do

the right thing and, when this is not possible, live with the discomfort and responsibility that comes with personal failure.

Finally, my approach to teaching around this issue and, more widely in relation to professionalism has developed. I have a different understanding of how prosocial behaviour might be promoted, particularly in relation to those situations where there may be a personal risk in acting. Reflection can be a useful tool here, but something more powerful is needed. This I think is more akin to critical reflectivity - a similar idea to Arendt's (1971) notion of thinking - which, if I understand it correctly requires a more rigorous examination of the self, of our assumptions, motivations, prejudice and bias. I am unable to think of a better way to express than provided in Arendt's original essay:

'The manifestation of the wind of thought is not knowledge; it is the ability to tell right from wrong, beautiful from ugly. And this indeed may prevent catastrophes, at least for myself, in the rare moments when the chips are down'. (Arendt 1971 p.446)

### **1.3 Overview**

With the exception of one publication (Ion and Beer 2003), the work presented was published between 2014 and 2018. In the sections which follow I develop a narrative which frames the central topic of the thesis, poor care, as a long standing problem, but one which has become particularly prominent since the failures at Mid Staffordshire NHS Trust in England came to light several years ago. Since that time, a body of academic work has developed which has sought to map the nature of the problem and suggest possible solutions.

This thesis is part of that body of work. Comprising thirteen publications, it provides one of the earliest accounts of the factors which nursing students take into account when faced with poor care (Ion et al. 2015), and to my knowledge, the first published account of how they justify these decisions (Ion et al. 2016). It provides one of the earliest systematic reviews of student encounters with poor care (Ion, Smith and Dickens 2017), and to the best of my knowledge, the first definition of poor care (Ion, Jones and Craven 2016) and, in doing this it

untangles the concept from error or mistake. It includes some of the early discussions of what educators might do to prepare student nurses for the possibility of raising a concern about care quality (Roberts and Ion 2014a, and Ion De Souza and Kerin 2018), along with educational resources for students and practitioners (Ion, Jones and Craven 2016, Gamble and Ion 2017 and Stenhouse et al. 2016). In addition to this it provides a unique application to health care failure, of Arendt's (2006) work on thinking and moral catastrophe (Roberts and Ion 2014a, Roberts and Ion 2014b). It concludes with the first two published papers to explore the implications of the Gosport inquiry (Jones 2018) for nursing as a whole (Darbyshire and Ion 2018a) and for nurse education (Darbyshire and Ion 2018b).

The work culminated in a national guidance on raising concerns about poor care which is published on the National Health Service Education Scotland (NES) website (Strachan, Ion and Roxburgh 2018). Not included as part of the thesis, this work can be seen in the appendix.

## **1.4 Methodological approach**

The thesis is submitted for the award of PhD by publication. It includes empirical work, a systematic review, educational resources and discussion pieces. I am first author of six of the publications, joint first author on two others (publications nine and eleven) and co-author of the remaining four. In all cases I was involved in the conception, planning, writing and final review of work.

The thesis draws on a range of methodological approaches including thematic, discourse and historical analysis, as well as skills in systematic review. From a philosophical perspective it draws on the work of Hannah Arendt - in particular, her attempt make sense of the question of individual accountability and intent at the trial of the Nazi Adolf Eichmann (Arendt 2006). My understanding of Arendt's position is that moral action and prosocial activity will only be activated when the individual has both a sense of right and wrong - a sound moral compass - and also, critically when they are able to have a meaningful internal dialogue in which they consider their actions in relation to this. While Arendt's

ideas are only discussed explicitly in two of the publications, her thoughts on the role of the individual influenced all the work to some degree.

## **1.5 Background**

The work is concerned with the role and responsibilities of nurses and student nurses who are witness to instances of poor care. It argues that these bystanders are obligated to take action in the face of care failure, that there is evidence which confirms that, for a variety of reasons, they sometimes do not act and that, in order to address this problem consideration must be given to the education and preparation of practitioners for the world of clinical practice. Finally, it makes suggestions and provides examples of how this might be done. It is presented against a background of concern about aspects of the quality of care provided by health services across the world, with much of this related to nursing care in particular.

While international professional and ethical guidance make it clear that nurses are expected to prioritise patients' welfare and ensure their safety (Nursing and Midwifery Council 2015, American Nurses Association 2015, ICN 2012), there is now, a well-documented and long-standing evidence base indicating that these priorities are not infrequently ignored, forgotten or overridden (Reader and Gillespie 2013, Manthorpe et al. 2016). Sometimes, this may be a consequence of committed and competent staff trying to manage competing priorities under very difficult circumstances. It may also be an outcome of errors or mistakes. This does not, however, account for all instances of care failure. Regrettably, this is sometimes the result of individual acts of omission or commission, which should be considered as poor care. It is the latter which is the focus here.

## **1.6 What is poor care?**

Poor care refers to actions or omissions by health care staff that involve deliberate neglect, abuse, or incompetence, systemic and personnel failures, including combinations of the aforementioned. It may or may not lead to serious

or even fatal consequences for patients. Where errors and mistakes and episodes of missed care may lead to the same serious outcomes, these can be distinguished from poor care in that the former are unintentional actions which are a result of human or organizational factors. To further clarify, poor care refers to what might be called failures of health care humanity where, for example, patients are abused, ignored, left unkempt or uncared for, neglected or otherwise treated as unimportant (Ion, Jones and Craven 2016).

### **1.7 What is the context?**

Following on from the scandal at Mid Staffordshire NHS Trust (Francis 2013) and, more recently at Gosport War Memorial Hospital (Jones 2018), where systemic care failure is thought to have cost the lives of many hundreds of elderly patients, healthcare in the UK is under particularly significant scrutiny (Traynor and Buus 2016). These high profile cases might be seen as touchstones of professional failure and public alarm. There are, however, many others, perhaps lesser known or less well remembered, but equally troubling instances of widespread poor care, for example at the Vale of Leven (McLean 2014), Morecambe Bay (Kirkup 2015), Winterborne View (Bubb 2014, Phelvin 2014, Plomin 2013), Alder Hey (RLCI 2001), and Ashworth Hospital (Fallon 2001).

Poor care is not, however, a purely British issue. Malmøed et al. (2014) have argued that abuse, neglect and inadequate care are realities for patients in many countries - a claim borne out by Hindle et al. (2006) in their analysis of eight inquiries in six countries. In a more recent review of patient neglect in health care settings, Reader and Gillespie (2013) noted widespread public concern around the issue in both Europe and North America, reporting on evidence of its occurrence across these continents, as well as in Asia and Africa.

It might be tempting to argue that this is a recent phenomenon and evidence of a modern malaise in the health care professions. This would be to ignore the historical record which clearly indicates that abuse and neglect of patients has always been with us (Ion and Beer 2003, Ryden-Grange 2015).

It would be similarly incorrect to think that the poor care problem has been resolved in the wake of the fallout from these scandals - in an interview in February 2017, Sir Robert Francis, Chair of the Mid-Staffordshire inquiry made it clear that he felt another failure on the scale of Mid /Staffordshire was now inevitable in the UK health system (Ford and Lintern 2017). Francis did not have to wait long. In mid-2018 in the UK, the inquiry into care at Gosport War Memorial Hospital in England reported that the lives of as many as six hundred and fifty people may have been shortened as a result of the inappropriate prescribing and administration by nurses of powerful combinations of opiates and sedatives to frail elderly patients in the absence of any clear indication of clinical need (Jones 2018). Only a few months after this in December 2018, the BBC (2018) reported abuse of adults with learning disability at Muckamore Abbey hospital in Northern Ireland between 2014 and 2017. The report described a culture of tolerating deliberate harm of residents by nursing staff, in which staff failed to raise concerns despite the fact that, in some cases the lives of patients 'were compromised'

Poor care does not just occur across an organisation as a systemic type failure as for example, happened at Mid Staffordshire and at Gosport. It may in fact be more prevalent at an individual level as a result of single instances of abuse, neglect or incompetence of some form or other. Examples of single instances of poor care can be found in work by Hazleton et al. (2011), Monrouxe et al. (2015) and Rees et al. (2015). Further examples can easily be located with a basic search of the Google search engine using terms such as 'poor nursing care', 'nursing abuse' or 'nursing neglect'. Examples identified include a story published in the Sunday Times (Sunday Times 2018) which reports on nursing students from Edinburgh University uncovering abuse of dying patients while on practice placement. A similarly story was reported on the BBC news website in 2014. The report of staff behaviour makes for grim reading

'The court was told one man had his foot stamped on deliberately and another was nearly tipped out of his wheelchair. The vulnerable victims were also pelted with bean bags and balls at their heads "for entertainment" '

In a final example, in 2015, the Independent reported on the sentencing of nursing staff from a South Wales Hospital who had been found guilty of 'wilful neglect' following the falsifying of clinical records.

### **1.8 What are the consequences of poor care for patients?**

In addition to the six hundred and fifty deaths at Gosport, it is estimated that several hundred unnecessary deaths occurred at Mid Staffordshire NHS Trust as a result of care failure (Francis 2013). In his report into care at the Vale of Leven in Scotland, MacLean (2014) found evidence that thirty-four avoidable deaths occurred.

Although profound, the reporting of mortality statistics does not necessarily capture the full nature of patient suffering caused by poor care. A clearer view of this is provided by Reader and Gillespie (2013) in their review of patient neglect in healthcare. They identified examples of rudeness and failure to meet patient hygiene and pain relief needs in two South African obstetric units (Jewkes et al 1998), failure to assist bedridden patients in German homes (Goergen 2001), the ignoring of patients and allowing unnecessary delays in attending to their needs in Norwegian nursing homes (Malmedal et al. 2009), and failure to provide adequate nutrition and hydration in American nursing homes (Zhang et al 2011). Further examples can be found in Masala-Chockwe and Ramukumba (2015) and Chockwe and Wright (2011) whose work with student midwives in South Africa revealed examples of registrants; ignoring patient's cultural preferences, 'screaming' at a patient in the operating theatre, sleeping while on duty and failing to provide emotional support to a woman whose baby had died before birth.

A similarly stark picture of the impact of poor care is provided in the UK Parliamentary and Health Service Ombudsman's (2011) report that detailed ten cases of care failure across the English NHS, quoting one relative as saying:

‘Our dad was not treated as a capable man in ill health, but as someone whom staff could not have cared less whether he lived or died’ (P1).

The idea that the life of a loved one could appear to be of so little value to those charged with their care is profoundly troubling. Perhaps most disturbing of all is the evidence that has emerged over recent years regarding the involvement of American medical and nursing personnel in the torture and degradation of enemy combatants in Iraq, Afghanistan and at Gauntanamo. Mohr’s (2009) chilling summary makes very discomfoting reading:

‘... 60 years after the Nuremberg trials, America’s healthcare professions are faced with the knowledge that their members have been complicit with abetting torture and concealing evidence or remaining silent about brutalisation of human beings in their care’ (p289).

## **1.9 Why does poor care occur**

Over the past few years a good deal of interest has focused on why poor care occurs and what might be done to prevent it (Darbyshire 2014, Fagan, Parker and Jackson 2015). Randall and McKeown (2014 ), for example have argued that structural issues around service funding and staffing are the root causes, while others suggest that the problems lie in the increasingly acute and demanding nature of health care (Paley 2013 and 2014) and the associated need to revise down expectations of what can realistically be delivered. For Timmins and DeVries (2014 and 2015) a combination of these factors has inured some practitioners to suffering and led to the development of cultures of care which are sub-optimal. In Publication Six, Roberts and I explored the problem from a different perspective. We took the view that poor care - at least in the context of what occurred at Mid Staffordshire NHS Trust, might be best understood as the result of instrumentalism in which the needs of the organisation to improve efficiency, meet targets and operate within budget, lead to prioritising of ends over means. Where this occurs in healthcare situations, the priority to meet targets around admission and discharge, for example,



overrides the requirement to provide high quality care to vulnerable patients, and the outcome is invariably poor care. We argue that the antidote to this outcome of instrumental rationality was to be found in Arendt's (1971) concept of thinking.

### **1.10 How has the sector responded to poor care?**

Revelations about abuse, neglect and incompetence have raised serious concerns about participants at all organisational levels and the systems within which they practice. They also raise uncomfortable questions about the role of professional regulators and the nature of health care education, including both content delivered and the academic staff who deliver it.

The ever growing body of published reports, which have sought to understand and explain the most high-profile failures, have invariably recommended change across a range of domains, including; the configuration and funding of services, the education and training of professionals and also in the mechanisms by which those who are witness to poor care might be encouraged and /or empowered to speak out about it. In the UK for example, Francis (2013) made 290 recommendations in his report on Mid-Staffordshire, while the subsequent Freedom to Speak Up (Francis 2015) report ran to over 200 pages in its discussion of raising concerns and how organisations might be more open to hearing bad news, and reflective and responsive when this is brought to their attention. The focus of the Willis Commission (2012) which explicitly made reference to Mid-Staffordshire and care failure more broadly, was exclusively on education in the aftermath of these failings - the report recommended a radical overhaul of nurse education in the UK. The impact of these and the many other recent reports which have followed health care scandal have been profound. From a regulatory perspective in the UK, it could be reasonably argued that the fall-out from Mid Staffordshire alone has been the single most influential driver behind the development of the recently published new standards for nurse education (NMC 2018b). Even before these standards have been adopted providers of nurse education have seen a change in the way in which the NMC

has chosen to monitor provision with an increased emphasis on the identification of risk - particularly as this relates to clinical practice.

Where the NMC has focused on changing professional guidance when required, along with a fundamental review of its expectations of providers of nurse education and the programmes they deliver, the focus of Government and employers has perhaps been more concerned with the development of methods for managing risk. In Scotland the introduction of national system for monitoring the quality of the practice environment experienced by student nurses and midwives has been introduced (NES 2016), along with national guidance on the raising of concerns by student nurses about standards of care (Strachan, Ion and Roxburgh 2018). Work from this thesis informed the latter and I am one of the authors who wrote the guidance.

Clearly organisational issues such as budget priorities and their impact on staffing, environment and other key resources are likely to directly influence the actions of groups and individuals within systems. As Roberts (2016 and 2017) has argued, however, it would be misleading and disingenuous to ignore the role of individual motivations responses and actions arising from personal belief, values, intrinsic moral conviction or education.

### **1.11 What is known about the perpetrators of poor care?**

As well as trying to understand why poor care occurs, much thought has been given to the nature of the perpetrators. At a regulatory level the Nursing and Midwifery Council has, through its standards for education and practice (NMC 2010 and 2018b), made clear its position on the requirement that those who seek to enter the profession must be of good health and good character - the emphasis here is on ensuring that only those with the 'right' disposition and whose health does not compromise their ability to practice according to professional expectations, enter nurse education programmes. Its introduction of revalidation for registrants every three years was a further addition to strengthen its protection of the public.

Allied to this has been an ongoing discussion of whether or not the changes in nurse education over the past twenty years - specifically the introduction of nursing to the higher education sector and the subsequent requirement that all pre-registration programmes be at graduate level - has created a generation of nurses who are 'too posh to wash' and somehow lack fundamental attributes such as a caring and compassionate attitude (Scott 2004, Wright 2011 Aubeeluck et al 2016).

### **1.12 Who witnesses poor care?**

Poor care can be witnessed by anyone who has reason to be in contact with health care workers. This includes colleagues from the same discipline, or from the wider multidisciplinary team, as well as health care staff in training, support workers, administrative staff, friends and family members of patients, as well as patients themselves. The focus in this work is on poor care witnessed by nurses, including student nurses. These witnesses, or bystanders can play a significant role in ending unacceptable practice. This was noted by Francis (2015) in the Freedom to Speak up Review in which it was made explicit that healthcare organisations should foster a culture in which raising concerns was viewed as part of normal business and evidence of a healthy work environment. Included in this culture was the need to ensure that structures and processes were in place to enable formal raising of concerns and that all healthcare professionals in training should be provided with education on how to go about speaking up.

### **1.13 Do those who witness poor care report it?**

One of the most troubling questions which has emerged from both the Francis Report (2013) and the Gosport Inquiry (Jones 2018) relates to whether or not those staff who witnessed poor care spoke up about it. Given the professional, ethical and moral guidance that underpins health care work, it is clear that they should have done so. In both cases there is evidence to say that some staff did raise their concerns, but that others, perhaps the majority, chose to remain silent.

In the aftermath of Mid Staffordshire this provoked a sustained discussion about whether it was reasonable to assume that the bystanders to poor practice at Mid Staffordshire, had, as a result of a number of contextual factors, simply not seen the appalling standards of care which had become entrenched practice, or whether these had been witnessed and subsequently either not processed as unacceptable, or, seen as such and passed over (Paley 2014, Rolfe 2013 Darbyshire 2015).

The reality is that we cannot really know whether staff did see and did not report, or did not see poor care at Mid Staffordshire or Gosport. There is no data to confirm or disconfirm this. Moreover there is unlikely to be any unless we expect those on the scene to admit to having seen unacceptable practice and to have ignored it.

Publications Three and Four from this thesis form part of a developing body of literature which suggests that reporting does not always occur and that those who choose not to do so find strategies to justify their inaction.

#### **1.14 What are the expectations of individuals who witness poor care?**

From a professional perspective, guidance provided by regulatory bodies invariably makes it clear that staff have a duty to respond to and raise their concerns if they are concerned about patient welfare. By way of example, section four of the Code of Ethics of the International Council of Nurses (ICN 2012) states that the nurse must take:

‘....appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person’

There is no ambiguity here and it is clear that a nurse who fails to act is in breach of this guidance. An expectation that the registrant will take action is also made clear in the Nursing and Midwifery Board for Australia’s Code of

Ethics for Nurses (NMBA 2013) where Value Statement One makes it clear that nurses must:

‘... take steps to ensure that not only they, but also their colleagues, provide quality nursing care. In keeping with approved reporting processes, this may involve reporting, to an appropriate authority cases of unsafe, incompetent, unethical or illegal practice. ‘(p3).

In the UK a similar position is made explicit in the Code (NMC 2015), which states that registered nurses must:

‘... work within the limits of your competence, exercising your professional ‘duty of candour’ and raising concerns immediately whenever you come across situations that put patients or public safety at risk’

This guidance, which is further reiterated in the regulators guidance on raising concerns about poor care (NMC 2018), makes it clear that patient safety is paramount and that there is an expectation that concerns will be addressed proactively. To conclude that behaving otherwise might be either negotiable or discretionary is unacceptable. As such failure to address poor care is a direct breach of standards, which puts the witness(es) of such abuse, neglect or incompetence at odds with the expectations of the regulator and may incur professional sanction. Of course, and central to this thesis, the existence of a standard or expectation does not mean that it has been internalised or accepted by an individual, or that it will be operationalised. Publications Nine and Ten explicitly address this issue.

## **1.15 Summary**

In summary, the existence of poor care is a reality in the UK and beyond, and has been over an extended period. The consequences of this for patients, their families and friends are significant. Moreover although guidance makes it clear that those who witness it must address and report, it is apparent that not all do

so. This failure to raise concerns inevitably exacerbates suffering, perpetuates injustice and makes it more likely that abuse, neglect or incompetence will occur again in the future. Bearing in mind these observations, there is an urgent need to address the position of those who are witnesses to care failure.

As Skarlicki and Kulik (2005) have argued in a different context, bystanders can play an important role in addressing injustice and unfairness in the workplace. Their decision to act is, however, likely to be influenced by a number of factors. They must, for example, have an understanding of the professional / ethical and organisational guidance, rules and expectations which govern breaches of acceptable conduct or practice. They must also have a clear sense of ethical conduct - put simply, they must understand the difference between right from wrong and good from bad.

They need to believe that, on balance, their intervention is likely to have a positive outcome and they must understand the process and procedure to be followed when a decision to act has been made. Finally, they need to have the courage and resilience to act upon their convictions.

In turn those who advocate action by bystanders, must have a clear sense of both the contextual and intra-personal factors which influence third party behaviour when considering raising a concern. Where possible they must find ways of encouraging positive action in the face of barriers and reasons for inaction, while also encouraging those things which promote prosocial and altruistic behaviour. It is these issues which are the primary concern of the publications which comprise this thesis.

## **2. Chapter Two**

### **2.1. Aim of chapter**

The aim of this chapter is to describe the assumptions, theoretical underpinning and philosophical positions which have guided the work. In addition it describes the individual publications presented as part of the thesis, including their methodological orientations where relevant. It also details my contribution to each. Finally it provides an account of how the thesis developed over time and of the relationships between the publications. In doing this it makes the case that that:

1. Poor care is a significant and long standing reality for patients, nurses and educators
2. There is clear professional, legal and moral responsibility to take action when poor care is witnessed
3. Despite this and contrary to an expressed personal commitment to provide good care, some of those who may witness it are able to provide justification for their decisions to remain silent in the face of poor care,
4. Those who say they would or have reported poor care, do so from a commitment to strongly held personal values and a sense of professional accountability,
5. Education and the development of critical, reflective thinking are crucial to the development of nurses who can speak out in the face of care failure.
6. Senior nurse educators and practice leaders must be prepared to rethink their relationships if significant and lasting change is to occur.

The central argument of the thesis is that poor care in health settings is a significant issue, that it sometimes goes unreported and that in order to address this, nurse education must change the way it prepares students and, in some cases, its relationship with practice placement providers.

## **2.2 Underpinning assumptions and theoretical position**

### **2.2.1 Underpinning assumptions**

The work is underpinned by four key assumptions.

First that poor care is an unpleasant reality across the world, with a long-standing history and one which results in significant suffering. Evidence to support this view is provided earlier in the thesis. Second, legal, professional and ethical guidance is unequivocal about the requirement that practitioners speak out to protect the vulnerable. Third, while much has been said about the difficulties that whistleblowers may face - Publications Four, Five and Six contribute to this argument - individuals are fundamentally free to choose how they act. This is not to say that action is sometimes, or often difficult - anyone who has spoken against authority will know this. Rather, it is to say that in almost all cases we are free to choose our actions, albeit with consequences. Finally, while the focus of the work is on individual responsibility, this has to be seen in context. More specifically, while individuals are obligated to speak out and acts of moral courage may always be required, real change will only take place if consistent action is taken at the most strategic levels.

### **2.2.2 The professional, legal, ethical and moral framework surrounding healthcare professionals**

Nurses are professionally, morally and legally bound to challenge care which is harmful, regardless of their personal concerns about doing so. The professional obligations of the nurse have already been outlined in section 1.13 above. The discussion here then is on the legal, ethical and moral position of witnesses to poor care

Practitioners are subject to the laws of the country in which they work. At the extreme end of the spectrum, poor care may overlap with criminal activity, for example in cases of patient abuse. It is possible therefore that a member of staff who witnesses, or is aware of, financial, physical, psychological or sexual abuse



of a patient may breach the laws of that country if they choose to ignore the action. In doing this they invite legal sanction.

Health care has sought guidance from a range of ethical and moral frameworks to help consider the way to best respond to difficult situations and dilemmas which arise in work with vulnerable people (Edwards, 2009). These invariably draw on Anglo-European traditions such as deontological, utilitarian/consequential, virtue or principle-based approaches. With the exception of utilitarian/consequence based systems where it might be possible to construct an argument that a greater good could be served by privileging the needs of the many over the individual, these principles offer little room for doubt when applied to the problem of how to respond to poor care. Applying Kant's categorical imperative, often interpreted as,

‘Do unto others as you would have them do unto you’ (Edwards, 2009, p. 838),

it is hard to see a case which allows for inaction in the face of abusive, negligent or incompetent care. Similarly in virtue ethics, where for nurses virtue is commonly taken to mean behaviour which is aligned with kindness, care, sensitivity and courage, it seems very unlikely that nurses could legitimately argue that allowing the continuation of preventable distress through the failure to intervene is a legitimate course of action. The same conclusions are reached when an answer to the problem of poor care is sought through application of Beauchamp and Childress (2013) principles of beneficence, non-maleficence, justice and autonomy. Commonly interpreted as do good, do no harm, act fairly and respect the rights of the person, the health worker who is witness too, but ignores poor care, is clearly at risk of breaching one or more of these (Gamble and Ion, 2017).

### **2.2.3 Freedom to act**

There is now a good deal of evidence to indicate that speaking up about poor care can be challenging. There are very real difficulties associated with whistleblowing (Francis, 2015) and it is important to acknowledge that the decision to keep quiet in the face of poor practice may be ‘understandable’, or at

least the only reasonable option open in some cases. It would, after all, be unreasonable to expect ordinary people to act in circumstances where only heroes are equipped to do so. There is a risk, however, that in acknowledging this difficulty, we provide an excuse for inaction in all cases, or at least in many cases where risk is relatively minimal, or perhaps tolerable. Duffy et al. (2012) for example, asked if we may be expecting too much of nursing students by expecting them to raise their concerns, while Glasper (2015) has emphasised the support that must be provided if challenging poor practice is to be a reasonable option. It is possible that this repeated insistence on the difficulty of reporting may inadvertently perpetuate a culture of avoidance and a belief that action is impossible - a position that is akin to arguing that we are unable to act.

Here I follow Roberts, (2016, 2017) who has also explored the issue of personal responsibility and poor care. Drawing on Sartre's concept of 'bad faith' and his position on individual freedom, he argues that, while reporting poor care may be an uncomfortable, or even very unpleasant experience, it is disingenuous for individuals to claim that they were unable to do so. In preference to the deterministic position taken by those who maintain that whistleblowing is often too dangerous to consider, Roberts, takes the view that we are fundamentally free to choose what we do, or do not do. By extension, if we opt to turn a blind eye to the occurrence of bad practice, we do so freely and not because we had no other option. Clearly the reporting of poor care may be difficult and occasionally beyond the capacity of some of us. As such it is certainly possible to argue that a failure to report poor care is understandable and as such excusable. However, to extrapolate from this that we have no option but to remain silent is to deny our individual freedom to make choices, take responsibility for our actions and inactions and, in doing so, accept the consequences.

#### **2.2.4 Strategic action**

Much has been written and done in the years since the failings at Mid Staffordshire were reported on by Francis (2013). The nature of the problem has been described and discussed in the academic journals and in numerous official reports and guidance documents. The NMC (2015) has published new ethical and professional guidance for practitioners, and new standards for educational

programmes (NMC 2018). National guidelines on the raising of concerns by students has been published in Scotland (Strachan, Ion and Roxburgh 2018) and it is an NMC requirement that education providers have policies in place to support students who encounter poor care. Despite this, as I write, the BBC (2019) has just reported on the abuse of adults with learning disability at Whorlton Hall in the UK. Although the central argument of the thesis is that individuals must act, coordinated action from leaders at a strategic level is essential for change to occur and if toxic cultures of care are to be eradicated. Publications Twelve and Thirteen outline what this might mean for the nursing profession as a whole and specifically for Deans of Schools of Nursing, Directors of Nursing and for all registrants in leadership positions

In summary, the thesis is built upon the following positions:

1. Poor care is a reality,
2. Failure to report poor care is a breach of moral, professional and sometimes legal guidance,
3. Individuals are free to make choices about their actions and inactions, albeit with consequences.
4. Sustained, real change will only take place if those in strategic leadership positions commit to making it happen.

# Relationship between papers

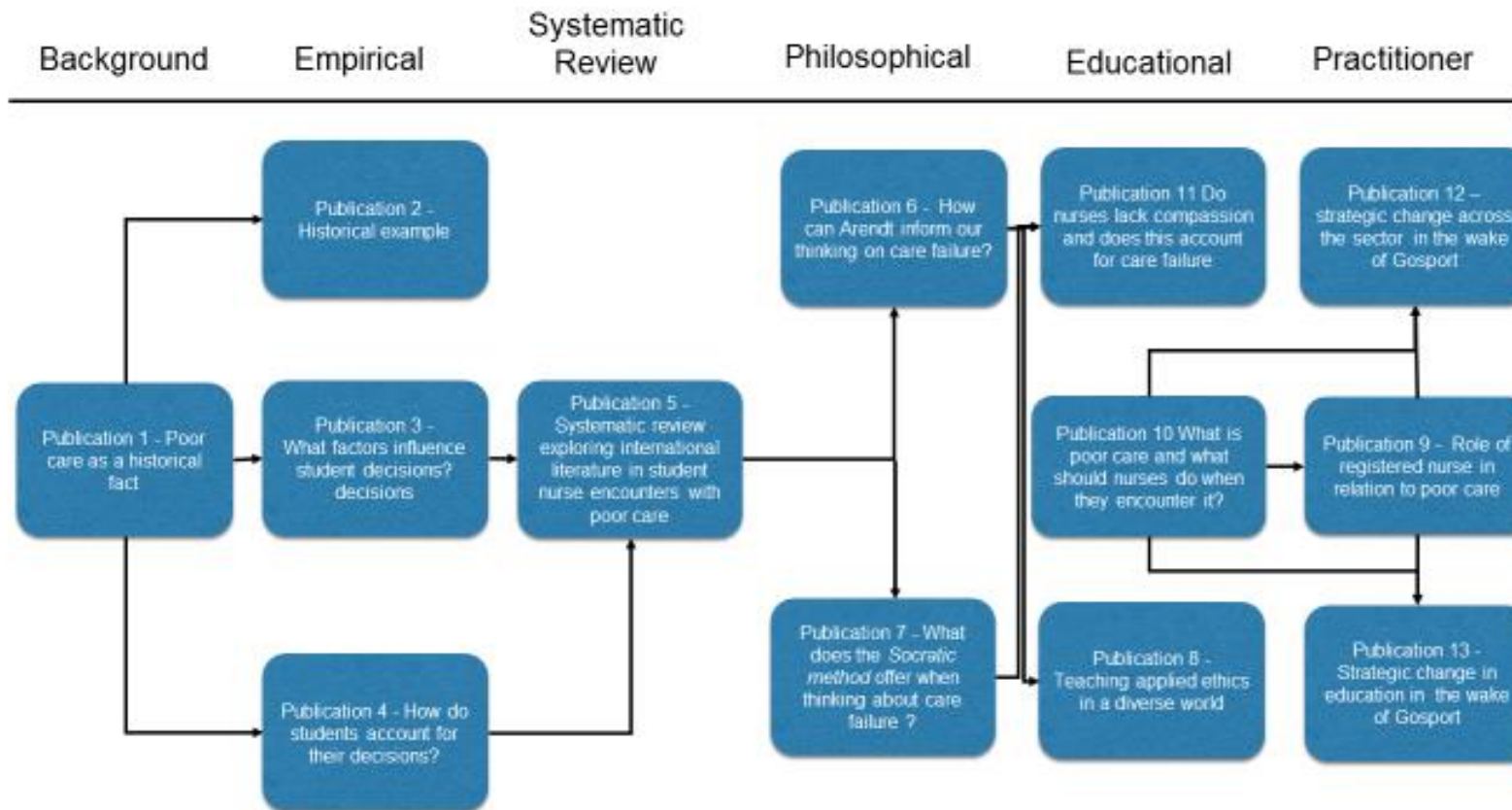


Figure 1 Figure one provides a diagrammatic representation of the relationship between publications

## **2.3 Synthesis of publications**

In this section I provide a synthesised narrative of the publications which comprise the thesis. I follow the diagrammatic representation set out in Figure 1 above, explaining how the overarching argument develops across outputs. The nature of the PhD by publication route is that while the narrative presented here is linear and chronological, the work itself grew organically, with papers sometimes written simultaneously and at other times sequentially.

### **2.3.1 Background**

Publications One, is a discussion paper and provides a historical backdrop against which the rest of the work is developed.

Here I establish the case that poor care, ineptitude and mistreatment of vulnerable people has been a long standing feature of health care and that it is not, as some might like to argue, a recent phenomenon. This is important for the overall thesis as it suggests that the issues which contribute to the development of the problem, and the potential solutions which might be applied are unlikely to be simple and may well be multifactorial.

### **2.3.2 Empirical Papers**

This historical argument is strengthened in the first empirical paper, Publication Two. This draws on a specific case from the late nineteenth century. Using newspaper accounts as the data source, it examines how a failure in care, which resulted in the murder of an asylum inmate by a fellow patient, was accounted for by the contemporary press. Taken together, Publications One and Two make the case that neglect, incompetence, failures of omission and commission, and hubris have a history, which stretches back well into the nineteenth century at the very least.

Publication Three deals explicitly with the question of how student nurses respond when faced with evidence of poor care. While professional guidance (NMC 2015) is clear that instances of poor care must always be reported,

anecdotal and empirical evidence suggests that this is not always the case. I wanted therefore, to understand what factors influenced student decision making. Using thematic analysis this publication considers the reports of thirteen student nurses who described the factors they would consider when making a decision about whether or not to report poor care. Drawing on the same data set, Publication Four, examines the interviews from a different perspective. Using discourse analysis it explores the function of the accounts provided by students to justify their decisions to comply (raise a concern), or not comply (not raise a concern) with professional guidance concerning how to respond in situations where care is unacceptable. The data indicates that participants who presented reasons for not reporting concerns took care to present their decisions as inevitable and largely outside their control - choices that would have been made by any other reasonable person. In contrast, those who provided accounts of raising issues attributed their actions to internal characteristics - issues of personal character and morality and a commitment to doing the right thing. In both sets of accounts participants took care to present themselves in the best possible light, even when this meant privileging the needs of self over those of patients.

### **2.3.3 Systematic review**

Publication Five is a systematic review. It was conceived as my understanding of the field began to develop and as I realised that I needed to better comprehend the international literature. It also provided me with an opportunity to test out an emerging assumption that the issues which faced the students I worked with in the classroom were not unique. The review identified a limited number of papers (n=14) on the topic - nursing and midwifery student encounters with poor care. It confirmed that this is an international problem encountered across the world and that as noted in Publications Three and Four (both of which are included in the review) there is evidence that students do not always address poor care.

#### **2.3.4 Philosophical papers**

Publications six and seven were written in sequence over a relatively short period of time. They grew out of a need to understand the phenomenon of systemic, large scale care failure and, more specifically, the role of the individual within this. Both are rooted in the failings at Mid Staffordshire (Francis 2013). The uniqueness of both publications lies in their attempt to understand poor care not as system level matter, nor as a result of individual moral failure, but rather as a consequence of the inability to critically engage with the patient experience. More specifically, they utilise the work of Arendt (2006) who framed widespread participation in the holocaust as an outcome of instrumental thinking. She argued that this enabled participants to focus their thinking at the level of process and organisation (means) without being troubled by the ends of that process. Publications Six and Seven argue that, at Mid Staffordshire, in their overriding focus on meeting targets in relation to waiting lists, admissions, discharges and other tasks, those involved failed to engage with their primary work - the alleviation of patient suffering. In Arendt's terms this failure to think - to engage with an internal moral dialogue - allowed ordinary people to ignore the suffering of vulnerable others in their care? Having employed this argument in Publication Six, Publication Seven presents a corrective to instrumentalism, by arguing that nurse education must take steps to promote the ability to think critically, to reflect and to be sceptical. Using the story of Socrates as an example, it argues that a critical perspective must be actively developed if we are to expect practitioners to engage in the kind of internal and external moral dialogue that is required to avoid the slide into instrumental, process driven approaches to care.

#### **2.3.5 Educational papers**

Publications Eight, Ten and Eleven were developed as educational resources. Publication Eight was designed to stimulate discussion and thinking among educators in relation to both the highly personal nature of nursing work and the potential for this to degenerate under certain conditions into poor care. It argues for a reinvigorated approach to ethics teaching with an accompanying commitment to the development, through education and rehearsal, of moral

courage. It directly addresses the argument put forward by students in Publications Three and Four that speaking up about care failure can be onerous and personally challenging. Acknowledging this, it makes the case that action to activate moral responses is required if we are to expect nurses to act in pro-social ways when these might also have an adverse personal impact. Publications Ten and Eleven were designed as resources which academics and practitioners might engage with to develop their own critical thinking skills in relation to poor care. Each contains theoretical content along with a series of reflective questions which are designed to engage the reader and challenge them to think about their notions of good care and how they might respond to instances of neglect, abuse or incompetence on the part of colleague.

### **2.3.6 Practitioner papers**

Publication Nine was written for practitioners and academics. It provides a clear statement about professional, legal and moral expectation in relation to poor care. As well as providing an accessible account of why nurses must act when they encounter unacceptable practice, it gives examples of how this might be done. While its focus is on the care of older adults, its central message is applicable across care settings more generally.

Publications Twelve and Thirteen were written as direct responses to the report into care at Gosport War Memorial Hospital (Jones 2018). Both were written for practitioners and educators with a particular focus on those in strategic positions. Where the earlier work was developed to understand, account for and promote changes in practice at the individual level, these final papers argue that unless these changes are embraced by those in positions of power, there is a high likelihood that similar failures will occur again.

## **2.4 Original contribution of the thesis**

This section details the original contribution of the work. In doing so it situates the thesis in the context of other related work on poor care and the response of the sector in relation to this. Three strands of work have evolved - specifically in the aftermath of Francis (2013) report into failings at Mid Staffordshire. These



relate to actions taken by the regulator and Government, by researches and by educators.

First both the Nursing and Midwifery Council and the General Medical Council have taken steps to make more explicit their expectation that failures, errors and mistakes are managed more openly and transparently. Each has published guidance on raising concerns (NMC 2018c, GMC 2012), and both have committed to a joint position on the Duty of Candour (NMC /GMC 2014). The publication of the Code (NMC 2015) and the revised Standards for Education (NMC 2018b) can be seen as further evidence of the regulatory response to care failure.

At government level , for example in Scotland, action has been taken to increase the monitoring of the student experience of practice learning (NES 2016), in part as a proxy to monitor the quality of care.

In term of education, the focus has largely been on the development of mechanisms to ensure students understand the process for reporting poor care, which is a regulatory requirement. Again in Scotland the development of national guidance on raising concerns (Strachan, Ion and Roxburgh 2018) has been an initiative supported by government and developed by educators and practitioners.

In terms of the research base, this is summarised in Publication Five which provides a systematic review of the research evidence concerning students encounters with poor care in the practice learning environment.

The originality of the work presented lies in the following contributions.

1. Paper Two provides a unique insight into a specific historical incident in which a murder committed by an asylum inmate was reported in the local print press. Aside from the contemporary newspaper reports, there are no other published accounts of this incident.
2. Although preceded by Belafontaine (2009), Publication Three provides the first sustained, peer reviewed exploration of the factors which

influence student decisions about whether or not to report poor care witnessed on placement. In outlining these, it clarifies for educators how they might strengthen their guidance for students in relation to raising concerns.

3. To the best of my knowledge, Publication Four remains the only work to examine the discursive function of the explanations which students provide when accounting for decisions about raising concern. In doing this it foregrounds the issue of self-interest and indicates areas which educators might productively consider when trying to promote pro-social action, which meets the expectations of the professional regulator.
4. Publications Six and Seven are unique in their application of Arendt's ideas on moral catastrophe to the area of care failure. Others have sought to explain this by recourse to system related matters, including underfunding, staff shortages and problems in the preparation of health workers. Another line of explanation has suggested it is the result of the malign intent of individuals. The application of an Arendtian perspective, locates the problem in the tendency to focus on process and ends and, by doing so, overlooking and over-riding the needs of the vulnerable person in need of care. In doing this it opens up the possibility that the potential for complicity in significant care failure may be much more widespread than might be thought. It also suggests an antidote to the corrosive effects of instrumental approaches, namely the development of critical reflexive thought.
5. Taken as a whole, the work provides a sustained account of the reasons given for both action and inaction in the face of poor nursing care. Much of the related work to date has focused on why poor care occurs, with an emphasis on system failure of one sort or another. A further area of interest has been the personal characteristics of those who abuse or neglect patients as a result of direct intent or incompetence. This work differs in that it seeks to understand and explain why those who witness poor care sometimes choose to remain silent about it. It emphasises the

importance of these witnesses and their moral and professional responsibility to raise concerns. In exploring reasons for actions and omissions, it indicates areas for attention by educators and places these in a broader theoretical argument which makes the case that third parties are more likely to speak up if they are able to engage in an internal critical dialogue, based on a sound understanding of professional accountability. In short, it applies Arendt's notion of thinking as a corrective to inaction when faced by evidence of poor care

## **2.5 Description of individual publications and account of contribution to each**

**Publication One: Ion R, M and Beer M, D (2003) Valuing the past: the importance of an understanding of the history of psychiatry for health professionals, service users and carers. International Journal of Mental Health Nursing 12, 4, 237-242. doi 10.1046/j.1447-0349.2003.t01-1-x**

I developed the idea for this discussion paper and designed its structure and the key issues to be addressed. I wrote the majority of the publication.

The work explores the relevance of history to contemporary mental health care. Written in 2003 it argues that an awareness of the past is important to both those who work in and those who receive support from health services as patients or carers'. In making this case it addresses three points of particular relevance to this thesis. First, the mistreatment of the most vulnerable in healthcare settings has a long history - poor care is most emphatically not a recent phenomenon. Second, while some of this may have been driven by personal malevolence and focused intent to harm, much more is likely to be a consequence of a combination of self-belief, indifference and an inability to take account of suffering. In making this point, it raises the uncomfortable possibility, that while it may be comforting to attribute abuse and neglect to others, who are in some way fundamentally different to ourselves, it is more likely that harm is

caused by ordinary individuals without deliberate intent and that, moreover it may be more prevalent than is commonly thought. Third, that knowledge in health care is provisional, that practice is historically situated and that an awareness and understanding of this can alert us to the possibility and probability of abuse, failure and incompetence in the present. The argument here is that modern health professionals should be alert to the potential for their own custom and practice to contain the seeds of poor care.

**Publication Two: Ion R, Pegg S and Moir J (2014) Nineteenth century newspaper accounts of a murder committed by an inmate of a Scottish asylum. *Journal of Forensic Psychiatry and Psychology* 25 (2) 164-175 doi.org/10.1080/14789949.2014.903503.**

I developed the idea for this paper, collected the data from newspaper archives, applied for ethics approval, and determined the method of analysis to be used. The analysis of data was shared with co-authors and the bulk of the writing is mine.

Published in 2014, this discourse analysis explores the way in which local newspapers portrayed a murder committed by a patient at the Royal Dundee Lunatic Asylum in 1896. While gardening in the grounds of the hospital under the care of a member of staff, the perpetrator attacked and seriously injured that person with a spade and then killed a fellow patient who attempted to intervene. The paper examines the degree to which the contemporary reports from several different newspapers framed the episode as an unavoidable tragedy which was a consequence of the unpredictability of the madman. In doing this, they exonerate the hospital authorities of blame - specifically in relation to claims of incompetence or neglect - while simultaneously presenting a version of events where incarceration of the 'lunatic' is a necessity. The following points are relevant to this thesis. In the first instance, regardless of the newspaper accounts, it is difficult to see this case as anything other than a failure of care resulting in death and serious injury for the victims, and increased security and a further reduction of freedom around the assailant. The analysis illustrates the powerlessness of the insane perpetrator and the ability of those in authority to

determine the climate in which concerns about care are examined. The degree to which this is achieved can be seen in the silence of the accused, when set against the reports of the media, which, without exception develop an account which is favourable to the hospital.

**Publication Three: Ion R., Smith K., Nimmo S., Rice A.M., and McMillan L (2015) Factors affecting student nurses' decisions to report poor care witnessed while on practice placement. Nurse Education Today. doi: S0260-6917(15)00077-5 [pii].**

I conceived this paper, designed the study, applied for ethics approval, organised data collection, led the analysis of data and wrote most of the resulting output.

Where Publication One illustrates the potential for care failure in the here and now by focusing on aspects of the past and Publication Two examines a specific historical case in some detail, Publication Three deals explicitly with the question of the factors which student nurses describe as influencing any decision to report poor care. Its planning grew out of an interest in the potential for health professionals to fail those in their care, but also out of the practical question of how students might respond to instances of care failure. The idea for the work came about shortly after the Francis (2013) report into care failure at Mid Staffordshire NHS Trust and in an environment where education providers were being asked to consider what mechanisms they had in place to encourage students to report poor care witnessed as part of placement experience. At the point of publication it was one of only a handful of empirical papers which examined this question in relation to nursing students. The paper, which is a thematic analysis of thirteen interviews with students which took place in one UK university indicates that nursing students do encounter poor care and that their decisions to report this are influenced by factors other than the incident of concern. More specifically, they consider the potential impact of raising a concern on them and their future career. In doing this, they note the potential for taking direct action to address a wrongdoing to result in damage to their future career and their relationships with others in the work environment.

They also consider whether any action taken by them is likely to result in meaningful change and whether their account of events would be taken over that of more experienced others. In contrast, where interviewees reported having taken action they often acknowledged these issues as potential problems but nonetheless took action as a result of personal / moral commitment and or adherence to professional guidance. The findings suggest ways in which educators might approach the preparation of students for practice. This might be by specifically addressing concerns about the consequences of raising concerns and by promoting prosocial behaviour.

**Publication Four: Ion R, Smith K, Moir, J and Nimmo S (2016) Accounting for actions and omissions: a discourse analysis of student nurse accounts of responding to instances of poor care. Journal of Advanced Nursing, 72, 5 1054 -1064. doi:10. 111/jan.12893**

I conceived this paper, designed the study, applied for ethics approval, organised data collection, led the analysis of data and wrote most of the resulting output.

Publication Four drew on the same data set used in Publication Three. However, where the latter used thematic analysis to identify the factors student nurses said they would consider when making a decision to report poor care, the former used Potter and Wetherell's (1987) discourse analysis to explore how participants justified their decisions. The findings indicated that when discussing reasons for inaction in the face of poor care, students provided an account where failure to act - in this case a decision to remain passive in the face of a breach of professional standards - was presented as a course of action that might be taken by any other reasonable person in the same circumstances. Invariably the reasons given for inaction were located outside the individual and in the environment or situation they did, or would, face if they raised a concern. As such these accounts served to preserve the moral and professional integrity of the participant who thus avoided the potential for

cognitive dissonance and the unpleasant self - evaluation that is associated with not doing the right thing in face of an ethical or moral dilemma.

Unlike those who provided justifications for failing to raise concerns about poor care and who did this by reference to external factors, those who had acted or said they would act drew on arguments which attributed their behaviour to internal characteristics. Unlike those who sought to explain their inaction by reference to external influence outside their control, this group attributed their behaviour to things which were intrinsic to them - elements of character or disposition such as a desire to follow the rules or an inability to ignore injustice. While participants differed in how they justified their behaviour, they shared a commitment to present themselves in the most favourable light possible. This suggests that despite professional exhortation to prioritise the care of patients, some participants chose to privilege self over others and that all took care to portray self in a way which minimised the possibility of negative outcome. As with Publication Four, the findings of this paper suggest approaches which might be taken to promote action over inaction. Here action might be promoted by undermining the strength of the arguments which are used to justify action and conversely by strengthening student understanding of the importance of following professional guidance and of the moral and personal benefits that might accrue from this.

**Publication Five: Ion, R, Smith, K, and Dickens G.L. (2017) Nursing and midwifery students' encounters with poor clinical practice: a systematic review. Nurse Education in Practice. 23, 67-75  
[doi.org/10.1016/j.nepr.2017.02.010](https://doi.org/10.1016/j.nepr.2017.02.010)**

I conceived this paper, applied for ethics approval, designed and conducted the search strategy, led the analysis of data and quality assessment of each reviewed paper. I took the lead in writing the resulting output. I was guided through this process by G.L.Dickens.

Publication Five is a systematic review of the international literature which examines nursing and midwifery students' encounters with poor clinical

practice. One of the first reviews to be published on the topic it was conducted in accordance with the relevant sections of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2010). Following a search of multiple databases fourteen papers were identified and reviewed. Papers Three and Four were included in the fourteen. The review found that students encountered poor care in practice settings across the world, with examples found in the literature from the UK, Australia, North America, South East Asia and Africa. This finding mirrors the work of Reader and Gillespie and Hindle et al (2009) who reported on evidence of care failure across countries and continents.

Paper five also confirms the findings in Publications Three and Four - that in a number of cases, and despite the seriousness of some breaches of professional conduct, students not infrequently choose to ignore poor care when they witness it. They invariably do this following an evaluation of the potential for negative consequences to arise in they take action against the perpetrator and/ or defence of the victim.

The paper concludes with the observations that further work needs to be done to understand the prevalence of poor care and to prepare students to deal with instances of poor care in a way which adheres to the expectation that nurses will protect the safety of the vulnerable.

**Publication Six: Roberts, M. and Ion, R. (2014) A critical consideration of systemic moral catastrophe in modern health care systems: A big idea from an Arendtian perspective. Nurse Education Today 34 (2014) 673–675. doi.org/10.1016/j.nedt.2014.01.012**

I conceived this paper, including the application of Arendt's ideas to the problem of systemic care failure. I worked with the first author to write the paper and made significant contributions to content.



This discussion paper explores the issue of poor care from a different angle. Where Publications Three, Four and Five examined the experience of poor care from the perspective of student nurses with a particular focus on how they responded, Publication Six provides a theoretical framework for understanding the occurrence of poor care and how its practice might become endemic across an organisation.

Drawing on the example of Mid Staffordshire NHS Trust it attempt to provide an account of how otherwise ordinary people can participate or tolerate system wide care failure. It deals with the question of why, despite professional guidance and expectation to the contrary, and in the absence of obvious malevolent intent, nurses and other health workers tolerated a culture of poor care and , in many cases , actively took part in it. Drawing on the work of Hannah Arendt - specifically her report on the trial of the Nazi Adolf Eichmann (Arendt 1961), the paper argues that moral failure occurs when individuals act without critical thought. At his trial Eichmann had offered a defence of his part in the organisation of the holocaust, which centered on his argument that he had simply been an administrator who had neither intent to harm the millions who died as a consequence of his work, nor ability to prevent this happening. Arendt argued that in presenting this defence, Eichmann demonstrated an inability for critical thought - a quality which she felt was fundamental to the identity of 'person'. It was, in her view, this failure which allowed the defendant to believe that had no choice but to act as he did and, which also appeared to enable him to maintain a sense of positive identify in spite of the enormity of his crimes.

Publication Six draws on Arendt's insights to argue that, while incomparable in terms of scale, the organisational and individual failures described by Francis (2013) in in his report on Mid Staffordshire might be explained in part using Arendt's ideas on thinking. It makes the case that the central feature of Mid Staffordshire was the development and propagation of a culture in which target driven instrumentalism took precedence over health care humanity and caring. In effect the reduction of waiting lists and the meeting of other targets became more important than the means by which this was achieved. It argues that this occurred because those involved as both participants and witnesses to failure

became inured to suffering as a result of their inability to critically reflect on the needs of patients and the real impact of their actions and inactions on fellow human being.

**Publication Seven: Roberts, M. and Ion, R. (2014) Preventing moral catastrophes in modern health care systems by facilitating the development of a Socratic ethos: A big idea from an Arendtian perspective. Nurse Education Today 34, 1411-1413**

I worked with the first author to conceive and write the paper and made significant contributions to content.

Publication Seven is a direct response to the argument developed in Publication Six. The latter outlines the nature of the problem, namely the failure to reflect and engage, through critical thinking, with unacceptable practice and poor care. Using the case of Socrates as an example, it puts the case for the development of practitioners who are able to ask uncomfortable questions about custom and practice and are sufficiently confident to do so. It also argues for a culture in healthcare where critical questioning is welcomed as part of good practice

**Publication Eight: Ion, R, DeSouza R, and Kerin, T. (2018) Teaching ethics: Intersectionality, care failure and moral courage. Nurse Education Today 62, 98-100 DOI: <http://dx.doi.org/10.1016/j.nedt.2017.12.023>**

I conceived and developed the structure for this paper. I identified key content and wrote the majority of the work.

Publication Eight compliments Publication Seven in that it was written for educators with an interest in how to help develop future nurses to respond effectively to care failure. Its key argument is that care failure is an ethical issue. It makes the point that if significant progress is to be made in relation to the

occurrence and reporting of concerns about poor care, then education needs to change, adapt and move beyond the traditional outlining of ethical codes and principles.

It is a direct response to findings in Papers Three, Four and Five and the argument presented in Paper Six. Specifically, it recognises that in some cases nurses may act in ways which allow them to bypasses the professional expectation that they will always act in the best interests of patients, while still maintaining a positive sense of their professionalism. This paper argues that a revitalised, case-based and real world focused approach to ethics teaching is required to address this matter. In addition it recognises the difficulties reported by those who consider raising concerns (See Papers Three , Four and Five) and makes the case that educators must take steps to support students to prepare in advance by not only developing their ability to think critically and make ethical decisions but also by developing their sense of moral courage.

**Publication Nine: Gamble, C and Ion, R. (2017). Poor care and the professional duty of the registered nurse. *Nursing Older People*. 29, 4, 20-24. <http://dx.doi.org/10.7748/nop.2017.e908>**

I conceived and developed the structure for this paper. I identified key content and wrote the majority of the work.

Building on the previous work, Publication Nine addresses the question of how nurses are expected to respond when they encounter poor care. It is implicit in most work in this area that those who are involved in working with vulnerable others will know how to recognise care failure when they see it and, in addition, that they will understand their professional obligations in relation to witnessing it. While this may be assumed, there is no reason to believe that the assumption reflects reality – the evidence suggests that it does not. This discussion paper was therefore developed to address this gap in the literature and was written for practitioners. The focus is on care of older adults - an area where care failure appears to be most common. Given what is known and explained in the previous papers in the thesis, Publication Nine, carefully details the moral, legal and professional expectations that nurses will take action in the face of poor

care. It also provides examples of what action might look like in this context and, in doing this, it aims to foster a belief that there is space for both informal and formal responses to breaches of professional standards.

**Publication Ten: Ion, R, Jones, A, and Craven, R. (2016) Raising concerns and reporting poor care in practice. Nursing Standard, 31, 15, 55-63.**

<http://dx.doi.org/10.7748/ns.2016.e10665>

I conceived and developed the structure for this paper. I identified key content and wrote the majority of the work.

Like Publication Nine, Publication Ten was written for practitioners and was published in Nursing Standard's Continuing Professional Development section. It is an educational resource which provides a clear definition of the meaning of poor care - cases of neglect, incompetence or abuse - and distinguishes this from the equally important, but fundamentally different, area of clinical error. Using a reflective approach the paper invites readers to consider their own response to situations in which where care quality may be an issue and to explore practical steps which might be taken to make it more likely that these would managed appropriately if they did arise.

**Publication Eleven: Stenhouse R, Ion R, Roxbrough, M, Devett P, and Smith S (2016) Exploring the compassion deficit debate. Nurse Education Today. doi:10.1026/j.nedt.2016.01.019**

In collaboration with Stenhouse and Roxburgh I conceived and developed the structure for this paper. Stenhouse and I jointly led the writing.

In the aftermath of Mid Staffordshire, as might be expected, there was a good deal of debate in academic nursing about how such a large scale failure might be explained. Much of this discussion centered on the claim that modern nurses lacked compassion. Publications Eleven was developed as an educational resource for those who wished to explore this debate in more detail. It examines

a range of papers on the topic, including Publication Six and an additional editorial I wrote (Ion and Lauder 2015), but which is not included in this thesis. The aim of the resultant output was to provide a critical summary of the arguments for and against the proposition that poor care was a result of a compassion failure and to invite readers to engage in a series of reflective tasks related to their understanding of the debate, the papers and possible solutions.

**Paper Twelve: Darbyshire, P and Ion, R, (2019) The Gosport War Memorial Hospital Report and its implications for Nursing. Journal of Advanced Nursing. 75, 258-263 doi.org/10.1111/jan.13781**

I conceived the idea for the paper. Identification of content and writing were shared with the first author.

Publication Twelve was written in the wake of the publication of the Gosport War Memorial Hospital Report (Jones 2018) which states that as many as six hundred and fifty elderly people may have had their lives shortened as a result of inappropriate prescription and administration of opiate and sedative medication. It argues that the Registered Nurses who participated in this regime by giving, in most cases without question, dangerously high levels medication without clinical indication were accountable for their actions and omissions. It makes the point that accountability is a core component of the role and identity of the registrant and that, while it may be a difficult responsibility to shoulder, it is one which cannot be abdicated.

**Publication Thirteen: Darbyshire P and Ion R (2018) The Lessons of Gosport for nursing education. Nurse Education Today. 70, 130 -135 doi.org/10.1016/j.nedt.2018.08.018**

Working with the first author, I conceived and jointly wrote this paper.

Developed as a companion piece to Publication Twelve, this paper makes the case for education as both part of the problem and an element in the solution to

the issue of poor care. Where Publications Eight, Nine and Ten outlined, discussed, developed and offered teaching solutions designed to address care failure in the classroom and workplace, Paper Thirteen, argues for change at the strategic level with an overhaul of the infrastructure of nurse education and in the relationships between academic and practice leaders. In particular it makes the case for a change in the relationships between nursing students and academic staff - from one which controls to one which empowers. The implication here is that control in the classroom will result in passivity in the practice environment and further instances of inaction and failure. It also makes the case for leaders in nurse education to consider their customary ways of working with the most senior of practitioners. Without a willingness to disrupt, speak out and sometimes offend senior practice partners, we argue that another Mid Staffordshire or Gosport is inevitable.

## **2.6 Summary and conclusions**

This chapter makes the case that poor care is both a long-standing and significant problem in health settings and, moreover, that it is one which sometimes goes unaddressed. This is established in Publications One to Five. Drawing on different academic perspectives, Publications Four, Five and Six outline reasons why nurses might opt act or not act in the face of care failure. In Publications Six to Eleven, a case is made for how this issue might be addressed through education and explanation. In Publications Twelve and Thirteen, both of which were written just after the publication of the Gosport Report, arguments are developed for change at a strategic level, which might involve new and more robust relationships between academic and practice based leaders. Overall the chapter adds to the developing discussion around nursing and poor care and the case that the issue:

1. Has a long history and while its portrayal may have changed over time, is not a symptom of a modern malaise,
2. Occurs across national boundaries,
3. Can have a profound impact on those who receive, deliver and witness it,
4. For a variety of reasons, often goes unreported by those witness it,

5. Occurs for a variety of reasons
6. That failure to report may be understandable but is ethically ,morally and professionally unacceptable,
7. Is a problem that is more likely to be addressed by witnesses who have clear sense of professional, ethical and moral guidance and who have been adequately prepared to deal with difficult decisions,
8. Can be addressed by individuals, but, also requires action at a strategic level.

### **3. Chapter Three**

#### **3.1 Aim of chapter**

The overarching argument of this thesis is that that poor care is an unpleasant reality, that it results in significant suffering and that legal, professional and ethical guidance is unequivocal in relation to expectations about the behaviour of individuals who witness it. Moreover, regardless of this, individual bystanders sometimes choose to ignore or overlook poor care. When asked to account for their inaction, they draw on a stock of accounts and explanations which position them as having little or no choice and therefore acting in a way which any other reasonable person might do. This, of course, does not help the patient. It also leaves the nurse in breach of professional guidance, moral expectation and, in some cases the law.

The aim of this chapter to discuss the thesis in relation to education, practice and research, and consider what more could be done.

#### **3.2 Education**

From an educational perspective there are a number of ways in which the problem of bystander inaction might be addressed. These include action in terms of recruitment to the profession, curriculum content and delivery. Over recent years there has been much discussion about selection and recruitment of candidates to the university nursing courses (Rogers et al. 2013, Wu et al 2015). Much of this has focused on the personal qualities of applicants, including their character and values (Waugh et al 2014, Lyon and Thompson 2018, Groothuizen, Callwood and Gallagher 2018). While these are important issues they are dealt with elsewhere and lie outside the immediate scope of this thesis. Having said this, it does seem critical to consider what applicants understand about the rigours of nursing before they enter educational programmes. Given the challenges of the work and the well documented negative consequences reported by some who have chosen to speak out (Francis 2015, Jackson 2014), it seems entirely wrong to bring candidates into a profession where their moral courage, resilience and capacity to cope may be



severely challenged, without making this clear in advance. It is worth asking then, if this is actually the case and if those who enter nursing fully understand what might be expected of them. There is good reason to think that this may not always be the case

According to Cabaniss, (2011) popular conceptions of the profession are often outdated and frequently depict an image that harks back to a non-existent halcyon past in which selfless young women assisted heroic male physicians. A recent review of twenty one studies by Girvin, Jackson, and Hutchinson (2016) found similar misconceptions about the work of nurses, which were also echoed by Tuckett, Kim, and Huh, (2017) and Glerean et al. (2017). If, as seems likely, applicants draw on this pool of cultural information when considering a career as a registered nurse, it is hardly surprising that they may feel overwhelmed when faced with the reality of clinical work. If the profession expects those who enter to fully understand the nature of the work and the personal commitment it requires, then it needs to be take steps to ensure this. There are some simple messages which might be conveyed in both recruitment campaigns and more generally when presenting the work of nurses. While it can be tremendously rewarding and provides many opportunities, nursing is hard, nursing is difficult, and it requires skill, alongside personal qualities such as kindness, trustworthiness, and, at times, moral courage. In addition nurses need keen intelligence, a sense of curiosity, an eye for detail and a commitment to what is often denigrated as 'basic care', but which would be better framed, as it is through the eyes of patients, as essential or fundamental care. It is rarely if ever glamorous - how could it be otherwise when it involves supporting the troubled, the sick, the dying and the bereaved? It is challenging and places a burden on the individual. Part of this burden is the heavy responsibility of accountability which comes with professional registration. Those who have some understanding of this on entry to the profession, and accept it as a reality may be better equipped to deal with the fallout that can sometimes result when taking action to protect the vulnerable. Unless we can be confident that those who enter the profession fully understand the responsibilities they have committed to when doing so, it would be unreasonable to expect individuals to

act against self-interest if they have no sense that this might be a requirement of the role at the earliest point possible.

Educators should also consider how they prepare students for the practice environment. One of the main aims of this work has been to make explicit the professional moral and legal expectations which face those who encounter poor care.

Those responsible for education programmes and for continuing professional development need to be confident that all nurses fully understand the ethical frameworks upon which the profession is built and that they understand how these apply to clinical practice. Without this we are expecting individuals to make difficult choices and decisions based upon experiences and knowledge gained outside the discipline and we cannot be certain that this alone will suffice.

Although individual moral frameworks are developed in a variety of ways across a lifetime, there is a clear need for educators and employers to provide robust ethics education which adequately prepares nurses to deal with ethical dilemmas, such as the reporting of poor care within the complex systems in which many will work. While professional bodies are invariably explicit that education providers must address ethical issues in their programmes, the manner in which this is done is left to the institution. This in turn may be dependent on the interests and inclinations of individual faculty. This suggests that there may be room to strengthen the ethics component of many undergraduate and continuing professional development programmes, not least by more tangibly integrating the “real worlds” of clinical practice with ethical theory and philosophy. Woods, (2005) for example, argued over ten years ago that ethics education for nurses may not be fit for purpose and in doing so called for nurse academics to review their teaching approaches. Work by Grady et al. (2008) also found that exposure to ethics education amongst American nurses and social workers was variable. Of equal importance they found those had received it were both more confident and more likely to take moral action. Robinson et al., (2014) similarly reported that enhanced applied approaches to

ethics teaching can have a positive impact on behaviour in the practice setting – specifically, that participants felt more able to respond to ethical challenges, including unethical practice by others. More recently Chao et al. (2017) demonstrated that ethical decision making competence amongst student nurses could be improved using a web-based teaching package. In summary there is evidence to indicate that ethics education should be strengthened and that when this occurs, carefully designed interventions can have a positive impact on both knowledge and action in the field. Educators need to review their approaches to ensure that the workforce is better prepared for the challenges presented by clinical practice. Unless we can be certain that this is the case, it is simply wishful thinking to trust that they will always do the right thing.

Educators also need to give thought to the fact that regardless of personal knowledge and ethical understanding, the act of raising a concern or reporting poor care is likely to be stressful and will most often require a degree of moral courage - the idea that individuals will act in the face of possible risk to self if they believe that there is a 'right' course of action that must be followed to achieve a greater good.

For Hamric, Arras, and Mohrmann (2015) three conditions need to be met before an action can be considered to be morally courageous. First it needs to involve some degree of risk to the person - action in the absence of risk may demonstrate any number of qualities, but does not require moral courage. Second, the action must be directed toward some desired social good. Without this it may be brave, but cannot be an example of moral courage. Third the actor must have thought through the potential consequences of their actions and determined that, despite the risk, intervention is required. This latter point distinguishes courage from reaction in the heat of the moment. This final point is dependent upon the person being able to think through and consider a range of issues and evaluate the consequences of choosing a specific course. The ability to think critically is a key component of this process. In their recent systematic review of teaching methods used to develop critical thinking Yue et al. (2017) argued for the importance of this skill, but noted that while discussion is not in short supply, there is relatively little empirical evidence to guide our

teaching in terms of how best to develop the attribute. What little we know indicates that methods which directly engage learners in the evaluation of actions and the making of decisions seems to hold some promise. At the very least, educators need to review the emphasis they place on this skill and ensure that it is robustly addressed in preparatory programmes.

According to Gallagher (2011), moral courage is facilitated by practice. More specifically, courage is more likely to occur if we become habituated to using it. The issue here for educators and clinicians is to create opportunities for students and registered nurses to speak up, to challenge, debate, discuss and argue. This may be difficult in a profession which has traditionally valued conformity and deference to perceived expertise, and in a clinical world which seems to value the chimerical certainty of checklists and assessed competencies above all else. This may require a different approach to teaching and learning for many educational institutions – Goodman, (2013) comments on instrumentalism in nurse education are worth considering here - but, if today's students cannot do this in the classroom, then it is highly unlikely they will consider doing so in the practice setting. We need therefore to find ways in which moral courage can be developed and nurtured in nurses. This needs to occur in initial preparation programmes and beyond. Progress may be very slow unless the profession's senior leaders - in both practice and education- are prepared for, and take ownership of the problem by also making a commitment to change. Writing about the unethical treatment of prisoners from the 'War on Terror', Wocial, (2009) stated that:

'Nurse leaders must break their silence and speak out against the active or passive mistreatment of all members of the human family'. '(p294).

Mohr (2009) is equally clear in her assertion that nurse leaders must be unequivocal about their expectations of professionals. This must also be accompanied by an open debate which accepts the problem of poor care and nurses involvement in it, but which also makes a commitment to making the structural changes which have allowed it to flourish, such as the acceptance of a culture of silence. For example MacCurtain et al (2017) recently emphasised

the importance of the leader in encouraging bystanders to intervene in situation where colleagues are being bullied. Leaders, of course, are also human beings who may be subject to the same degree of professional censure from their 'superiors' for speaking up, as the most junior of student nurses. If they have been well chosen, however, they should be fully aware of the expectations of their roles, one of which is to lead by example.

### **3.3 Practice**

Having argued that failure to raise concerns about poor care may breach professional, ethical and legal guidance and that it is essential to robustly prepare nurses to do this, it is equally important to recognise that reporting will, in most cases, only happen if cultural norms in practice welcome difficult feedback. Only heroes will take the considerable risk of calling out poor care if the environment in which they do this is defensive, unwilling to listen and suspicious of the reporter. It is naive in the extreme to expect ordinary individuals to speak out in situations such as this. Much can be done, however to improve the likelihood that ordinary nurses will take action in the majority of environments where speaking out may at times be uncomfortable or even difficult, but is not toxic.

At the very least universities and health providers must have in place clear policies on how to report, along with processes for managing concerns. To avoid the disillusion and frustration that arises when investigations rumble on, these need to include timelines for providing meaningful feedback and clarity about the roles and responsibilities of those charged with investigating. The Scottish national guidance referred to earlier (Strachan, Ion and Roxburgh 2018) provides an example of this approach.

Education providers should also consider their approach to placing students in environments which are suspected to be problematic, for example, as a consequence of staffing difficulties, staff attitudes toward students or for some other related reason. There is now a wealth of evidence to indicate that students struggle in such places. Given this, it seems even more unlikely that

they would call out poor care in such a setting. While most providers struggle to find placement for their students and are understandably cautious to strike a practice area from the placement roster, we are morally culpable if we continue to place students in areas which we know to be problematic.

### **3.4 Research**

Research in this area remains relatively underdeveloped. What little work has been done has largely focused on two areas. The first of these, to which work from this thesis has contributed has explored reasons given for reporting or not reporting poor care. The second has examined the experience of those who have spoken out. Examples of this include work by Jackson et al. (2014), Jones and Kelly (2015) and Bichart et al (2016)

To date, however, there has been no large scale survey of registrants or students which examines the prevalence of poor care. This means that while we have many examples of the individual impact of this issue, we have no clear picture of the actual scale of the problem. Future research might usefully explore this with a view to determining both prevalence and specialty in which poor care is most likely to occur. It would be equally useful to know the range of types of poor care witnessed and the extent to which this is raised or ignored. It would also be helpful to gain a sense of geographical spread. The high profile scandals which have been widely reported in the UK in particular have been largely limited to discrete hospitals or places of care. As argued above, it is likely that the problem is more widespread and possibly more mundane - although no less distressing - regardless it would be very helpful to have a clearer picture.

Other areas which may be worth investigating include the development of case studies of areas where concerns have been raised and in which the response from leaders has been positive and proactive. It would be very useful to understand the circumstances which are likely to lead to a more positive outcome for the reporter and those who have been reported, and to disseminate this information widely.

Finally, from an educational perspective, it is important to develop understanding of how educators respond to and act when informed by student nurses of concerns about care quality. We know little or nothing about this, although it is likely to be one of the key factors which students consider when thinking about raising a concern - if students do not trust us, it is unlikely they will risk speaking about something which is commonly thought to often have a negative outcome. Without doubt the response and subsequent actions of the academic will also colour the progress and perhaps also the outcome of any investigation. In a world where placements are at a premium and where universities may be reluctant to upset providers, it would be interesting to understand if this plays a part in the academic response, and if academics have the moral courage to address the issue of poor care in the way I have argued in this thesis that others should.

### **3.5 A framework for education**

Having spent considerable time over a number of years considering the question of poor care and, in particular, how bystanders might be encouraged to respond to it, in the following section I outline a proposal for how education might best respond to the challenge. In doing this I address four issues.

#### **3.5.1 Strategy and strategic engagement**

Those with strategic level responsibility for education in both the University and in clinical practice must develop shared values, principles and priorities in relation to their expectations of student nurses, the workforce and quality of care. Their joint commitment to these must be visible and modelled through action and engagement.

#### **3.5.2 Expectations, process and its operationalisation**

The expectations of all parties in relation to the reporting of poor care must be clearly articulated to all. This should be done through teaching, discussion and debate and via the development of a clear process which outlines how

witnesses to poor care can raise their concerns. It should also address the expectations of those to whom reports are made. It must include timelines for reporting back on investigations and details of accountable officers in both education and practice with clear information about their roles and responsibilities. Guidance must also provide details of the circumstances under which information will be shared with other relevant stakeholders, for example when students from more than one university share a placement area, and the conditions under which a report will be made to the police and / or the regulator.

### **3.5.3 Teaching style, content and delivery**

Teaching should not simply address the process for raising concerns. It must also ensure students understand and are able to recognise poor care when they see it. It should include a strong and applied ethics component to enable students to make decisions based on principles and theory and not just personal values and preferences. Given the difficulties associated with speaking against authority, it would be sensible to ensure that content is also directed toward developing moral courage - at the very least this should provide opportunities to rehearse and practice having difficult or challenging conversations. This will most likely be made easier if students are encouraged to speak up and engage in ordinary classroom discussion - those who are silent in practice are likely to be similarly quiet in the classroom. Teaching must also foster an understanding of what it means to be accountable for action and omission. Without this, individuals may well think that reporting poor care is a matter of personal choice. If they fully understand the concept of accountability they will know that this choice is real, but that we are answerable for the decisions we make - there is no neutral position in relation to accountability.

### **3.5.4 Thinking, reflection and reflexivity**

One of the main themes of the thesis is the importance of thinking. Drawing on Arendt, I have argued that the ability to hold an internal dialogue with the self is essential for prosocial behaviour when action may result in adverse consequences. While much is made in nursing about the importance of reflection, this thinking is perhaps more akin to the critical reflexivity with which I



open the thesis. If we are to provide students and practitioners with what they need to report poor care, we must find ways to help them to move beyond the reflection which involves a superficial recounting of an event with an account of how they might have done something differently. Educators need to find a way to nurses are capable of the type of internal dialogue which requires an examination of motivation and self-interest , consequences for self and others and which is built on a solid understanding of applied ethical principles.

### **3.6 Conclusion**

Poor care is a threat to patient safety and dignity and damages the integrity of the profession. Concern about it has been reported in health services across the world. Evidence indicates that it sometimes goes unreported and that suffering results as a consequence. Legal, professional and ethical guidance make it clear that nurses have a duty to take action when they encounter it. Work to date has focused on exploring why care failure occurs, with scant discussion about the obligations of those who witness it. I have argued that the witness to poor care risks legal as well as professional sanctions if they remain passive and essentially 'look the other way'. Critically, failure to act in the face of abuse, neglect or incompetence leaves the witness in breach of all commonly accepted ethical guidance on how to respond when faced with moral dilemmas.

The likelihood of more proactive responses may be increased by, ensuring that those who enter the profession understand the responsibilities of the registrant, by the provision of applied education which directly addresses the problems faced by those who encounter ethical dilemmas in the practice setting, and by steps to develop and activate individual moral courage. Ultimately, significant change is only likely to take place where practice cultures truly welcome feedback and promote critical reflection, and in cases where this is proactively supported by those in leadership positions.

Finally, understanding of the scale of the problem and the empirical evidence for how best to prepare nurses to address it, remains relatively underdeveloped. There are clear opportunities for researchers to make a difference here.

#### 4. Full text of publications

The published articles cited below have been removed from this e-thesis due to copyright restrictions.

1. Roberts, M., Ion, R., 2014. Preventing moral catastrophes in modern health care systems by facilitating the development of a Socratic ethos: A big idea from an Arendtian perspective. *Nurse education today* 34 (12), 1411-1413 <https://doi.org/10.1016/j.nedt.2014.08.010>
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10. Stenhouse, R., Ion, R., Roxburgh, M., Devitt, P.F., Smith, S.D.M., 2016. Exploring the compassion deficit debate. *Nurse education today* 39, 12-15. <https://doi.org/10.1016/j.nedt.2016.01.019>
11. Darbyshire, P., Ion, R., 2019. The Gosport War Memorial Hospital Panel report and its implications for nursing. *Journal of advanced nursing; Journal of .Advanced .Nursing*. 75 (2), 258-263. <https://doi.org/10.1111/jan.13781>
12. Darbyshire, P., Ion, R., 2018. The lessons of Gosport for nursing education. *Nurse education today* 70, 130-135. <https://doi.org/10.1016/j.nedt.2018.08.018>

## 6. Appendix 1

The publications listed below have been removed from this e-thesis due to copyright restrictions.

1. Strachan, E. , Ion. R. 2018. Raising concerns in practice: a national approach for students, practice learning experience providers and higher education institutions in Scotland. National Strategic Group for Practice learning. Available from : [https://www.nes.scot.nhs.uk/media/4163133/national\\_raising\\_concerns\\_document\\_with\\_leaflet\\_2018.pdf](https://www.nes.scot.nhs.uk/media/4163133/national_raising_concerns_document_with_leaflet_2018.pdf)
- 2 Raising concerns: guidance for nurses and midwives. 2019. Nursing and Midwifery Council .Available from: <https://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives/>

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